Disabilities among refugees and conflict-affected populations

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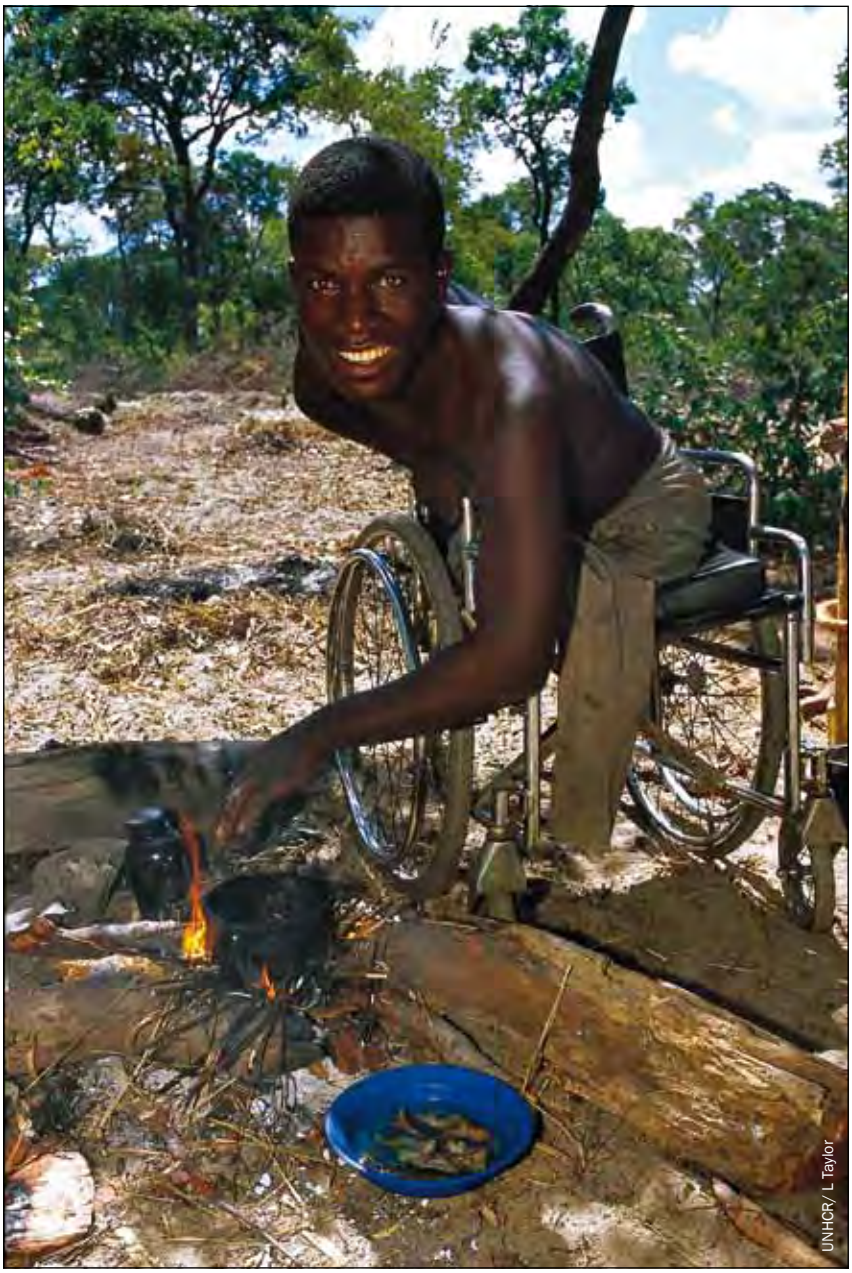
In 2007 the Women's Refugee Commission launched a major research project to assess the situation for those living with disabilities among displaced and conflict-affected populations.

People living with disabilities may be left behind during flight, or may not survive the journey; they are often not identified or counted in registration or data collection exercises; they are excluded from or unable to access mainstream assistance programmes and forgotten when specialised services are set up. They are often the most exposed to protection risks, including physical and sexual violence, exploitation, harassment and discrimination. The loss of family members or caregivers during displacement can leave persons with disabilities more isolated and vulnerable than they were in their home communities.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And their potential to contribute and participate is seldom recognised. Refugees and displaced persons living with disabilities are amongst the most hidden, excluded and neglected of all displaced persons.

Some refugees and displaced persons may have lived their whole lives with a disability. Others may have become disabled during the conflict or natural disaster which led to their flight. The disruption of health and social services during conflicts or after a natural disaster can deprive the local population, especially children, of essential preventative and curative medical services, resulting in permanent impairments which could otherwise have been prevented.

The Women's Refugee Commission was particularly concerned that displaced women, children and older persons face multiple discrimination on the basis of their gender, age and social status, as well as their disability. Women with disabilities are often exposed to sexual violence, domestic abuse and physical assault. Children with disabilities frequently suffer physical and sexual abuse, exploitation and neglect. They are excluded from education and not provided with the support to help them develop to their full capacity. In the Dadaab refugee camp in Kenya, Somali children with disabilities were sometimes tied up and had stones thrown at them, or suffered verbal abuse from other people in the community.

Mothers are often blamed for their children's disabilities and may suffer physical or sexual abuse from their husbands or other family members, and be harassed, stigmatised and abandoned as a result. Older persons with disabilities may be abandoned or neglected by family members who can no longer care for them; they may face extreme isolation and vulnerability and may be unable to access the basic health care, food and shelter they need to survive.

The Women's Refugee Commission mapped existing services for displaced persons with disabilities in five countries, identifying gaps and examples of good practice and making concrete recommendations on how to improve services, protection and participation for this neglected population. Field studies were carried out by local NGO service-providers and disabled persons organisations (DPOs) in Bhutanese refugee camps in Nepal, Burmese refugee camps in Thailand and Somali refugee camps in Yemen, and among urban Iraqi refugees in Jordan and urban Colombian refugees in Ecuador. Additional information came from Dadaab refugee camp for Somali refugees in Kenya and IDP camps in Sudan and Sri Lanka.

Key findings

Data collection:

In all the countries surveyed there was a lack of reliable and consistent data on the number and profile of displaced persons with disabilities. This problem was particularly acute in urban areas, where there was insufficient data on the number of refugees in general and little or no information on the number of refugees with disabilities. A lack of consistency in terminology and methodologies for data collection, cultural differences in definitions and concepts of disability, and lack of training or disability awareness amongst data collection staff all affected the accuracy of data. Inadequate or unreliable data meant that persons with disabilities were often not identified, and as a result appropriate services were not in place.

Physical infrastructure:

An additional problem in all the countries surveyed was that the physical layout and infrastructure of camps impeded access for persons with disabilities to facilities and services, including schools, health clinics, latrines, water points, bathing facilities and food distribution points. Difficulties with physical access and the poor design of camp buildings, including shelters, affected all aspects of daily life and increased the isolation of persons with disabilities. This was particularly the case in urban areas. In Jordan, researchers found that Iraqi refugees with disabilities rarely left their homes. Researchers did find some positive examples of adaptations to improve physical access; in Dadaab refugee camp, for example, wheelchairs were designed with special wheels for use on the sandy terrain.

Access to mainstream and specialised services:

As well as lack of physical access, the research also found that mainstream services were either inappropriate or did not cater for the specific needs of persons with disabilities. Food distribution systems were inaccessible for persons with disabilities in several countries, and there were no additional or special food rations. Mothers in Nepal and Yemen, for example, said that they could not get specially formulated food for children with cerebral palsy and cleft palates. Refugees in Yemen said that people with visual impairments were cheated during food distributions, or had their rations stolen. In Dadaab, on the other hand, the World Food Programme gave refugees with disabilities priority during food distributions so they did not have to wait in long queues, and members of the community were mobilised to help collect food rations for persons with disabilities.

All the field studies highlighted a lack of specialised health care, psychosocial support and counselling services for persons with disabilities. There were no specialist doctors or specialist therapy provision, a lack of specialised medicines and generally no referrals to external services. Health clinics were often physically inaccessible for persons with disabilities, who were not given priority treatment and had to wait in long queues. Those with visual or hearing impairments often faced communication difficulties. In some countries, such as Thailand, there were well-established physical rehabilitation and prosthetics programmes, whereas in others, such as Yemen, such services did not exist. Some positive examples of community outreach health programmes for persons with disabilities were found in the Bhutanese refugee camps and for older persons in the IDP camps in Darfur.

Education and training:

A more positive finding from the research was the availability of inclusive education for children with disabilities. In all the countries surveyed, children with disabilities were attending school and in some countries school attendance rates for children with special learning needs were high. In refugee camps in Nepal and Thailand there were successful early childhood intervention programmes to identify children with disabilities and help them integrate into mainstream schools. Classroom support was provided for refugee children with special learning needs and there was ongoing training of special needs support teachers, as well as mainstream teachers to help support inclusive education. Teaching aids and appropriate curricula were developed and children with special needs were provided with mobility aids and learning accessories – such as Braille text-books, talking calculators and large print posters – to support their learning.

In general, the research found that inclusive education could be a good entry point for persons with disabilities to access other services. For example, through early childhood intervention programmes, refugee children with disabilities could be referred to appropriate health services, and parent support groups were a positive starting point to provide psychosocial support to parents of children with disabilities.

Elsewhere, while children with disabilities were not actively barred from attending school, neither were they actively encouraged to do so. Attendance rates were low and dropout rates high. There was a lack of special needs support staff or training for mainstream teachers and a lack of appropriate teaching aids, flexible curricula and assistive learning devices – and school buildings were physically inaccessible. In Yemen, for example, children with visual and hearing impairments did not have spectacles or hearing aids which made it very difficult for them to continue at school.

There were some examples of successful vocational and skills training programmes which helped refugees with disabilities learn

useful skills and find employment. Bhutanese refugees in Nepal set up small grocery shops, barber shops and weaving businesses after participating in skills training programmes. Elsewhere, vocational training schemes were not adapted for people with disabilities or they were actively excluded. In nearly all cases persons with disabilities faced huge social, attitudinal and legal barriers in finding employment because of their disability, in addition to their status as refugees and outsiders.

Participation:

Nearly all the people with disabilities interviewed during the field research said that they would like to be more involved in community affairs, camp management, programme planning and decision-making processes. However, there were very few opportunities for the formal participation of persons with disabilities. There were some positive examples of refugees and displaced persons with disabilities forming their own organisations and self-help groups, for example in the camps in Thailand and Nepal, as well as some positive community awareness-raising initiatives.

In general, the Women's Refugee Commission found that there was little contact between displaced persons with disabilities and local DPOs. One of the positive outcomes of the research was to build bridges between local DPOs and refugee communities in several countries. In Jordan the involvement of Jordanians with disabilities from a local DPO[1] as researchers in the project exposed them to the challenges faced by the Iraqi refugees and led to the inclusion of Iraqis in some of their projects.

Supporting practice and influencing policy

In June 2008, the Women's Refugee Commission published a comprehensive report outlining the findings of its field research, as well as a resource kit for UN and NGO humanitarian field workers on how to work with and promote the inclusion of persons with disabilities.[2] The resource kit includes practical advice on how to make refugee camps more accessible to persons with disabilities and how to promote their full and equal access to mainstream services and facilities.

Since 2008, the Women's Refugee Commission has been working to influence both policy and practice to promote the rights of displaced persons with disabilities, for example putting together a guidance document for relief organisations operating in Haiti after the January 2010 earthquake.[3] The guidelines were sent through InterAction to all its members working in Haiti as well as to its Protection and Humanitarian Assistance working groups. They were also sent to the Protection and Education clusters in Haiti and were posted on the One Response website for Haiti coordination. The Women's Refugee Commission plans to follow up on this with training workshops for service providers in Haiti – a model the organisation hopes to replicate in several other pilot countries. At the policy level, the Women's Refugee Commission has been active in a coalition of NGOs advocating for a UNHCR ExCom Conclusion on disabilities, which is due to be adopted in 2010.

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1. http://www.landminesurvivors.org/

2. *Disabilities Among Refugees and Conflict-Affected Populations* and *Resource Kit for Fieldworkers* http://www.womensrefugeecommission.org/programs/disabilities

3. http://tinyurl.com/HaitiGuidance